South Carolina Department of Health and Human Services

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

REFERRAL FORM

P.O. Box 100127 | Columbia, SC 29202 | 803-264-6838 (O) | 803-264-6847 (O) |803-462-2580 (F) | www.scdhhs.gov

Instructions: *Please complete the following form and return it to the mailing address or fax number appearing above.*

Section I **Beneficiary Information** **Date: _____**

Name: _____Medicaid ID #: _____
Address: _____City: _____ State: _____Zip: _____
Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____)_____
Email Address: _____ Date of Birth:_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

If you are completing this form for the referral applicant, and are responsible for that individual, please indicate your relationship to the applicant. ☐ Spouse ☐ Parent ☐ Child ☐ Other (Explain) _____

Medicaid Eligibility: ☐ Yes ☐ No If yes, what is your date of eligibility? _____

Are there any additional Medicaid beneficiaries in your household who are interested in applying for HIPP services? ☐ Yes ☐ No
If yes, please provide the following information for each referral; and indicate additional names on the back of this form.
Name: _____ Medicaid ID #: _____
Name: _____ Medicaid ID #: _____

Whom may we thank for referring you?_____
Name of Referring Agency:_____ Address: _____Phone: (____)_____
Reason for Referral/Diagnosis: _____

Section II **Insurance Information**

Name of Insured: _____ Relationship to the Referral Applicant: _____
Primary Insurance Company Name:_____ Policy #: _____ Group ID#: _____
Address:_____City: _____ State: _____ Zip: _____ Phone: (____)_____

Name of Employer: _____ Employer Contact Rep: _____Phone: (____)_____
Address of Employer:_____ City:_____State: _____Zip: _____

Name of Insured: _____ Relationship to the Referral Applicant: _____
Secondary Insurance Company Name: _____ Policy #: _____ Group ID#: _____
Address:_____City: _____ State: _____ Zip: _____ Phone: (____)_____

Name of Employer: _____ Employer Contact Rep: _____Phone: (____)_____
Address of Employer:_____City: _____State: _____ Zip:_____

Section III **Supplemental Documents**

The following supplemental documents are required to complete your HIPP referral application. Please submit these documents to the mailing address or fax number appearing above as you obtain them. ***You DO NOT have to wait to submit all supplemental documents at one time.***

☐ Health Insurance Premium Invoices or Pay Check Stubs ☐ Health Plan Booklets or Summary of Benefits
☐ 4-6 Months of Explanation of Benefits (EOBs)